TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
American Specialty Pharmacy

Respondent Name
Texas A&M University System

MFDR Tracking Number
M4-15-3869-01

Carrier's Austin Representative
Box Number 29

MFDR Date Received
July 27, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Review of submitted documentation does not find a position statement from the requestor.

Amount in Dispute: $443.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "… Dr. Key was restricted from prescribing medications on this claim and the medications are not eligible for reimbursement."

Response Submitted by: Starr Comprehensive Solutions, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 21, 2015	Prescription Medication (Trezix, Cycolbenzaprine HCl 10 MG)	$443.00	$443.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.10 provides the requirements for billing pharmacy services.
3. 28 Texas Administrative Code §133.210 sets out the requirements for medical documentation.
4. 28 Texas Administrative Code §134.503 sets out the guidelines for billing and reimbursing pharmaceutical benefits.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 150 – Payment adjusted because the payer deems the information submitted does not support this level of service

- Comments: “Documentation does not support Trezix to be prescribed.”
- 176 – Prescription is not current
- W3 – Additional reimbursement made on reconsideration.
- B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.
- 193 – Original payment decision is being maintained. This claim was processed properly the first time.

Issues

1. Was the provider certified/eligible to be paid for the disputed services?
2. Is the carrier’s denial for Trezix due to lack of documentation in accordance with 28 Texas Administrative Code §133.210?
3. Is the carrier’s denial for Cycolbenzaprine HCI 10 MG due to lack of current prescription supported?
4. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
5. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code B7 – “This provider was not certified/eligible to be paid for this procedure/service on this date of service.” In their position statement, the insurance carrier states that, “Dr. Key was restricted from prescribing medications on this claim and the medications are not eligible for reimbursement.”

   Review of the submitted documentation finds that the services were provided by and billed by American Specialty Pharmacy, not Dr. Key. The insurance carrier’s denial reason of B7 is not supported because no evidence was provided to support that American Specialty Pharmacy was ot eligible to be paid for the services in dispute.

2. The insurance carrier denied disputed charges for the dispensation of the medication, Trezix with claim adjustment reason code 150 – “Payment adjusted because the payer deems the information submitted does not support this level of service.” Review of the general documentation requirements established by 28 Texas Administrative Code §133.210 finds that documentation is not required to be submitted with the medical bill for pharmacy services.

   If the carrier asserts that documentation not otherwise required by 28 Texas Administrative Code §133.210 is needed in order to process the medical bill, then the carrier shall make a request that complies with the requirements of paragraph (d) of that section as follows:

   > Any request by the insurance carrier for additional documentation to process a medical bill shall:
   > (1) be in writing;
   > (2) be specific to the bill or the bill's related episode of care;
   > (3) describe with specificity the clinical and other information to be included in the response;
   > (4) be relevant and necessary for the resolution of the bill;
   > (5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;
   > (6) indicate the specific reason for which the insurance carrier is requesting the information; and
   > (7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation.”

   The EOB denial itself does not meet the requirements of 28 Texas Administrative Code §133.210(d) because it does not contain the level of specificity required by the rule. No other documentation was found to support that a timely request for additional documentation was made by the carrier. Therefore, the carrier’s denial for Trezix due to lack of documentation is not supported.

3. The insurance carrier denied disputed charges for the prescription Cycolbenzaprine HCI 10 MG with claim adjustment reason code 176 – “Prescription is not current.” 28 Texas Administrative Code §133.10 (f)(3)(X) requires that the prescribing doctor’s information and a prescription number be included on the DWC066. Review of the submitted information finds that this information was provided as required. The submitted documentation does not find that the insurance carrier requested additional documentation in accordance

with 28 Texas Administrative Code §133.210. The insurance carrier's denial reason for Cyclobenzaprine is not supported.

4. For the all the reasons stated above, the disputed services are reviewed per applicable Division rules and fee guidelines. The MAR in for the disputed services is established by the AWP formula pursuant to 28 Texas Administrative Code §134.503 (c), which states, in relevant part:

   (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
   (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
   (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;
   (B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount …
   (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
   (A) health care provider

   The requestor is seeking reimbursement for the name brand drug, Trezix, NDC number 66992084010; and the generic drug Cycolbenzaprine HCl 10 MG, NDC number 59746017710. The disputed medications were dispensed on May 21, 2015. The MAR is calculated as follows:

Date of Service	Prescription Drug	Calculation per §134.503 (c)(1)	§134.503 (c)(2)	Lesser of §134.503 (c)(1) & (2)	Carrier Paid	Balance Due
5/21/15	Trezix	(3.35970 x 120 x 1.09) + $4.00 = $443.45	$368.60	$368.60	$0.00	$368.60
5/21/15	Cycolbenzaprine HCl 10 mg	(1.10000 x 90 x 1.25) + $4.00 = $127.75	$74.40	$74.40	$0.00	$74.40

5. The total MAR for the disputed services is $443.00. The insurance carrier paid $0.00. A reimbursement of $443.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $443.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $443.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	January 11, 2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.